County Flex Benefits

Enrollment & Change Form

OHR use only
Effective date:_____
Processed Date: _____
OHR Rep: _____

EMPLOYEE NAME: _____

ADDRESS: _____

MEDICAL PLAN ACTION:
[ ] enroll [ ] change plan [ ] add spouse/dependents [ ] delete spouse/dependents [ ] waive or cancel plan

MEDICAL PLAN SELECTION:	**MEDICAL PLAN COVERAGE LEVEL:**	**COST (from price sheet)**
[ ] Kaiser HMO	[ ] You	$_____
[ ] Aetna PPO	[ ] You & Spouse	$_____
[ ] Aetna Select Open Access	[ ] You & Children	$_____
	[ ] Family	$_____

DENTAL PLAN ACTION:
[ ] enroll [ ] change plan [ ] add spouse/dependents [ ] delete spouse/dependents [ ] waive or cancel plan

DENTAL PLAN SELECTION:	**DENTAL PLAN COVERAGE LEVEL:**	**COST (from price sheet)**
[ ] Delta Dental PPO Plus	[ ] You	$_____
[ ] DentaQuest EPO	[ ] You & Spouse	$_____
	[ ] You & Children	$_____
	[ ] Family	$_____

FLEXIBLE SPENDING ACCOUNT ELECTION:

[ ] Health care FSA annual amount: $_____ ($2500 maximum)
[ ] Dependent care FSA annual amount: $_____ ($5000 maximum)

EMPLOYEE & DEPENDENT ENROLLMENT INFORMATION:

	Name	**Sex**	**SS#**	**Birth date**	**Medical**	**Dental**
Employee:					[ ]	[ ]
Spouse:					[ ]	[ ]
Child:					[ ]	[ ]
Child:					[ ]	[ ]
Child:					[ ]	[ ]

IF ENROLLING IN KAISER HMO, YOU MUST DESIGNATE A KAISER PRIMARY CARE PHYSICIAN (PCP):

Employee: _____ PCP name & number: _____

Spouse: _____ PCP name & number: _____

Child: _____ PCP name & number: _____

Child: _____ PCP name & number: _____

Child: _____ PCP name & number: _____

EMPLOYEE ACKNOWLEDGEMENT & SIGNATURE:
I agree that care providers may furnish information to the insurers I have selected above concerning medical diagnosis, treatments, or services in connection with any condition for which I or my dependents seek care under a Howard County Government CountyFlex benefit plan. I also agree to have my salary reduced by the amount of premium required to pay for the coverage(s) I have selected above. I understand that I may not make a benefit election change except in the event of a status change as permitted under IRS regulations. I understand that if a status change occurs I must notify Human Resources **no later than 30 days** from the date of the status change, or I will not be permitted to make a benefit change until the next annual open enrollment period.

EMPLOYEE SIGNATURE:_____ **DATE:**_____
WORK LOCATION: _____**WORK #:** _____ **HOME #:** _____